HEALTH PROFESSIONAL RECOVERY PROGRAM (HPRP)

Saving lives … saving careers

DESCRIPTIVE REPORT
FOR THE ANNUAL TIME PERIOD

APRIL 1, 2004 - SEPTEMBER 30, 2005

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ACKNOWLEDGEMENTS

The Department of Community Health and the Health Professional Recovery Committee gratefully acknowledges the assistance of the following individuals for their contributions to this report about the Health Professional Recovery Program (HPRP). The Bureau of Health Professions will continue to rely on the experience and expertise of individuals from multiple groups of interest as we prepare future reports about the Health Professional Recovery Program (HPRP).

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EXECUTIVE SUMMARY

For the cumulative reporting period: April 1, 2004 to September 30, 2005

Michigan's Health Professional Recovery Program is designed to protect the public from the delivery of potentially impaired health care while encouraging and monitoring the recovery of health care professionals. These dual goals require a balance achieved by the way the program is structured. The legislation authorizing the HPRP empowers a multi-disciplinary, statewide Health Professional Recovery Committee with oversight of the program and also requires a private sector contractor, currently the Michigan Public Health Institute (MPHI). The Michigan Department of Community Health (MDCH) provides administrative services to the Committee as well as funding for the contract that arises, in part, from health professional licensing fees. The contract includes monitoring of voluntary cases as well as monitoring of regulatory cases referred by state licensing boards.

This Executive Summary addresses how the monitoring program is meeting its dual goals of public protection and encouraging recovery within the health care professional community.

Is the program protecting the public?

There are a number of ways to measure the effectiveness of the program. The information available to date examines how the program is structured as well as participation findings to answer this question. The most pertinent findings include:

- ***Wide availability:*** Michigan's program is available to each of 30 health care professions, and 7 student categories that are regulated under Article 15 of the Public Health Code. Of the professions eligible for the voluntary program, all but two (Registered Dental Assistants and Audiologists) have had participants in the program. Veterinary assistants fall under the general heading of veterinary medicine.

- ***Coordinated referral center:*** Although referrals may come from many sources, there is a single coordinated port of entry. The contractor separates referrals into voluntary cases or regulatory cases at the time of intake. Anyone wishing to make a referral may call a toll free telephone number at (800) 453-3784.

- ***Participation:*** For the reporting period April 1, 2004 to September 30, 2005, there have been 646 referrals to the program. 456 (70.6%) of those participants are first time referrals. The remaining 190 (29.4%) were referrals for readmission (referral for regulatory monitoring). Five professions account for 92.3% of the caseload: Nursing, Doctor of Medicine, Doctor of Osteopathic Medicine, Doctor of Dental Surgery, and Pharmacists. Please note that although nurses are the most represented profession in the program, this may be a function of the large number of nurses, and various other factors (e.g., the reporting environment, high amount of interpersonal contacts). Thus, an interpretation of the number of participants from a specific health profession who participate in the program as a valid and reliable measure for substance use disorders or mental/emotional disorders within that

health profession, or as a comparison of these health problems between professions, is not an accurate interpretation of the data.

- ***Refrain from practice:*** HPRP policies require the contractor MPHI-HPRP, along with the treatment provider team, to make a preliminary judgment during the intake process about the risk posed by the person being referred based on the information available. Those who are determined to be unsafe to practice are requested to refrain from professional practice until a complete evaluation is received from an approved evaluator. Under HPRP policies, failure to refrain from working if requested by the contractor can result in a referral for non-compliance to MDCH for potential regulatory action. The Health Professional Recovery Committee's (HPRC) policies also permits the program, with the assistance of the treatment provider team, to request health care professionals to refrain from working, as part of their written agreement, until they are determined safe to practice. Typically, this occurs following treatment and, depending upon the diagnosis, may include a graduated re-entry into the workplace with restrictions. If a relapse occurs, the health professional may be removed from employment and may be required to participate in a more intense treatment program. A relapse can also result in referral to MDCH for potential regulatory action. Regulatory action is defined as disciplinary action taken by a board or disciplinary subcommittee which could include a variety of sanctions up to and including a summary suspension of the license, registration, or certification if it is determined that an immediate threat to the public exists.

- **Compliance:** When individuals follow HPRP policies, procedures and signed agreements, they are considered compliant. Failure to do so results in a classification of non-compliance. Non-compliant participants are reported to MDCH for further action, as required by law. The overall compliance rate for the 1,408 individuals having involvement with the HPRP over this reporting period is 81.3%. This compliance rate includes compliant individuals who are currently active in the program (n=821). This is in addition to individuals who have been discharged after completing program requirements (n=324) for a total of 1,145 compliant participants. The following report includes other calculations for compliance rates according to program phase. This analysis excludes 35 individuals who were discharged for administrative reasons.

- **Professions with shortages:** Those who are being monitored are returned to work as soon as their impairing condition is stabilized and appropriate monitoring is in place. Of the 677 individuals in the monitoring phase, 630 or 93.0% represent nurses (n=460), physicians (n= 103 including 76 MD's and 27 DO's), pharmacists (n=42), and dentists (n=25). Often the approval for return to work may include certain limitations, such as the number of work hours or access to controlled substances. The ability of the health care system to employ monitored health care professionals helps employers to meet workforce needs. The public also is able to maintain continuity of care with a practitioner of their choice in a safe environment.

  Indeed, the public benefits when health care professionals return to work during the monitoring phase, and also when they stay employed after program completion in conjunction with safe and effective clinical performance. Ninety-one percent of the 2265 individuals who completed their written agreements arise from the five professions mentioned previously.

Of the 242 completions from these five professions, 177 were nurses and 18 were pharmacists. Both of these professions are experiencing critical shortages. In addition, another 37 physicians (30 MD's and 7 DO's) and 10 dentists have successfully completed the program.

- **Education and Outreach:** Due to changes in the contract with MPHI, the HPRP was not involved in any defined education and outreach programs during this reporting period. Rather, the Bureau of Health Professions decided to assume these responsibilities. To that end, an Outreach Worker position has been created within the bureau whose primary responsibilities will involve these duties. For this reporting period, the HPRP Contract Administrator assumed the majority of the outreach duties with assistance by HPRC members when requested.

Is the program assisting the health care professional's continuing recovery?

Substance use disorders and mental health disorders are treatable diseases that can be life threatening. Participation in the HPRP provides the opportunity to save a career from the damage of professional discipline and reporting of regulatory action to national data banks. However, should the health care professional not be initially successful in the voluntary program, regulatory monitoring can achieve the goal of assisting the health care professional to successful recovery by mandating involvement in the program as a condition of regaining or maintaining their license / registration.

Although a determination of whether the program is meeting the health care professional's needs during his/her continuing recovery is often anecdotal, the Health Professional Recovery Committee does have some data that helps to illustrate this point.

- ***Program completion:***
  The program is achieving its goal of returning health care professionals to professional practice. Of the 622 clients who have been discharged, 324 clients have met program completion requirements. This represents a 52.1% program completion rate.

  Discharged/ Program requirements met:

Discharged due to no qualifying diagnoses:	59
Discharged due to participants' completion of monitoring agreements:	265
Total:	324

- ***Monitoring agreements:***
  Monitoring agreements are written by the contractor during the intake phase and signed by the health care professional. Agreements vary depending on the diagnosis and framework for monitoring. Health care professionals benefit from these agreements in that the agreements provide a structured "best practices" model that provides specific direction towards recovery. As of September 30, 2005, there were 677 monitoring agreements in place. More detailed information about these monitoring agreements is described in Tables i, ii, and iii below.

Table i. Monitoring Agreement Length for All Active Participants (n=677):

Contract Length	Voluntary and Regulatory Participants	Percent of All Monitoring Agreements
One Year Contract	55	8.1%
Two Year Contract	81	12.0%
Three Year Contract	504	74.4%
Over Three Year Contract	37	5.4%
Total	**677**	**100%**

Table ii. Monitoring Agreement Type for All Active Participants (n = 677):

Contract Type	Voluntary and Regulatory Participants	Percent of All Monitoring Agreements
Out of State Contract	11	1.6%
Mental Health Contract	46	6.8%
Chemical Dependence Contract	435	64.3%
Dual Diagnosis Contract	175	25.8%
Pain Management Contract	10	1.5%
Total	**677**	**100%**

Table i indicates that the most common contract length is three years (n=504, 74.4%), followed by two years (n=81, 12.0%), one year (n=55, 8.1%), and over three years (n=37, 5.4%). Table ii shows that the largest percentage (64.3%) of participants (n=435) are being monitored for a chemical dependency diagnosis. Twenty-six percent (n=175) of those being monitored are being monitored for a dual diagnosis. Another 6.8% (n=46) of the participating health care professionals are being monitored for a mental health diagnosis and an additional 1.5% (n=10) are being monitored for pain management.

Table iii. Monitoring Agreements for All Active Participants According to Voluntary or Regulatory Status (n=677)

Contract Type	Number of Voluntary Participants	Voluntary Percent of a Particular Contract Type	Number of Regulatory Participants	Regulatory Percent of a Particular Contract Type
Out of State Contract	6	.9	5	.7
Mental Health Contract	36	5.3	10	1.5
Chemical Dependence Contract	352	52.0	83	12.2
Dual Diagnosis Contract	132	19.5	43	6.4
Pain Management Contract	6	.9	4	.6
Total for All Contract Types	**532**	**78.6%**	**145**	**21.4%**

As illustrated in Table iii, for every type of monitoring agreement, the percentage of health care professionals who are being monitored on a voluntary basis far surpasses those who are being monitored as a result of a regulatory basis. This means that as long as voluntary participants remain compliant, there is no regulatory action that is subject to public information and reporting to national data banks. This also indicates the program is reaching a segment of the professionals before they require state intervention.

- ***Relapse Prevention:*** Substance use disorders and mental health disorders are diseases that sometimes include denial or relapse. The monitoring program uses several methods to help prevent or detect relapse and address denial. All health care professionals participating in the monitoring program are required to call a toll-free number five days a week to determine if they need to provide a specimen for toxicology screening. In addition to these random drug screens, the program requires constant monitoring by those involved in the aftercare of the health care professional. These could include a worksite monitor, a physician/addictionist, a group therapist, a sponsor, and/or a mental health therapist. These monitors are required to report, as examples, any problematic behavior, non-attendance at required meetings, or suspected relapse.

- ***Reviews***: The Health Professional Recovery Committee adopted an appeal policy in 2001, which has since been amended and renamed as a review policy. Under this policy, those who take issue with decisions of the contractor regarding inclusion in the program, case closure, or any topic subject to individualization in the monitoring agreement, may file a review request with the contractor as part of the process to request a review of contractor's decision. During this reporting period, the Review Subcommittee received and reviewed a total of 21 requests.

Recovery Monitoring Agreements (RMAs):

RMAs are designed to be a "best practices" model for recovery. Dependent upon the diagnosis and the severity of the condition, this requires a considerable commitment of time and money for certain elements of the agreement, such as random drug screens, individual/group therapy, attendance at self-help group meetings, and regular medical appointments. Therefore, compliance with the program's requirements may be more difficult for those without adequate support (e.g., financial, insurance, social, employment). Data is not available at this time to assess reasons for non-compliance.

Reporting of Participation Data:

For this report, most data analysis combines both voluntary and regulatory participants. This report is based primarily on the data prepared by MPHI once they assessed the program contract requirements and following their review of program participant files.

Contractor Transition Issues:

The program underwent significant changes during this reporting period. The program was operated at different times by three different contractors and data transmission between the contractors did not occur as smoothly as had been expected. As a result, the current program contractor was required to enhance and modify the participant database so that program participation information could be accurately and appropriately captured. The HPRC is cautiously optimistic that in the event the program again undergoes a contractor change, the transition process will occur more smoothly than has occurred in the past.

Recommendations:

As the statutory oversight committee for the Health Professional Recovery Program (HPRP), the Health Professional Recovery Committee interacts often with the Department of Community Health/Bureau of Health Professions and the private sector contractor. The success of the HPRP relies on the positive interaction and collaboration of these partnerships.

During this reporting period, the program underwent significant changes and programmatic issues that required appropriate intervention and direction from the HPRC. In order to ensure that future issues are appropriately addressed, the HPRC proposes the following recommendations:

1. The HPRC recommends being informed, and their input sought, prior to any decisions made concerning changes in program contractors.

2. The chairperson of the HPRC, or whoever is designated by the HPRC membership, should be included as one of the participants on the Joint Evaluation Committee whenever bids are solicited and received for the program contractor.
3. The Director of the Bureau of Health Professions should also be included as one of the participants on the Joint Evaluation Committee, given that funding for the program comes from the bureau and immediate oversight of the program falls under their jurisdiction.
4. If the program contractor has issues with their contract or issues involving the contract administrator, those issues should first be addressed with the Bureau of Health Professions.
5. The HPRP Contract Administrator should be allowed to continue in their role as the liaison between the program contractor and the HPRC, consistent with past practice and the wishes of the HPRC.
6. The HPRC should be involved in the selection and evaluation of the drug screen subcontractor for the program to ensure that the chosen subcontractor is able to provide the required services.

INTRODUCTION

Michigan's Health Professional Recovery Program (HPRP) is designed to address the treatable diseases of substance use and/or mental health disorders among health care professionals who are otherwise qualified to practice.

This annual report contains information from April 1, 2004 through September 30, 2005, about the program. The information pertains to both voluntary and regulatory participants. Descriptors that identify any individual in the HPRP have been excluded.

For the Health Professional Recovery Committee, the multiple purposes of data collection and review for the program are to describe activities, to track trends, and to provide a foundation for strategic planning, program development, and on-going evaluation. Additionally, integrating the specific findings from this program with research in the fields of addiction medicine and mental health may add to the body of knowledge in these disciplines.

The Health Professional Recovery Committee (HPRC) Data and Statistics Subcommittee, the Michigan Public Health Institute (MPHI), and the Michigan Department of Community Health (MDCH) jointly prepared this report. Questions about the data or findings should be directed to the MDCH Bureau of Health Professions (*see Appendix C).*

The report follows this format:

- **Organizational Overview:** This section addresses historical and administrative aspects of the monitoring program including how authorizing legislation and policies are implemented.

- **Program phases:** The three phases of the program (i.e., intake, monitoring, and discharge) are described here.

- **Key Definitions:** Voluntary and regulatory categories assigned to participants, administrative discharges and readmissions are defined in this section.

- **Findings:** This descriptive, statistical report is divided into two parts. First, the overview discusses findings about how health care professionals move through the program, participation by phase or profession, and compliance information. Key illustrative figures are included within the overview text. The second part emphasizes findings by program phases. Tables referenced in this section are found in Appendix A.

- **Appendices:** The appendices provide: (A) tables from the Findings Section, (B) a glossary of abbreviations and definitions, (C) contact information, and (D) Health Professional Recovery Committee membership.

ORGANIZATIONAL OVERVIEW

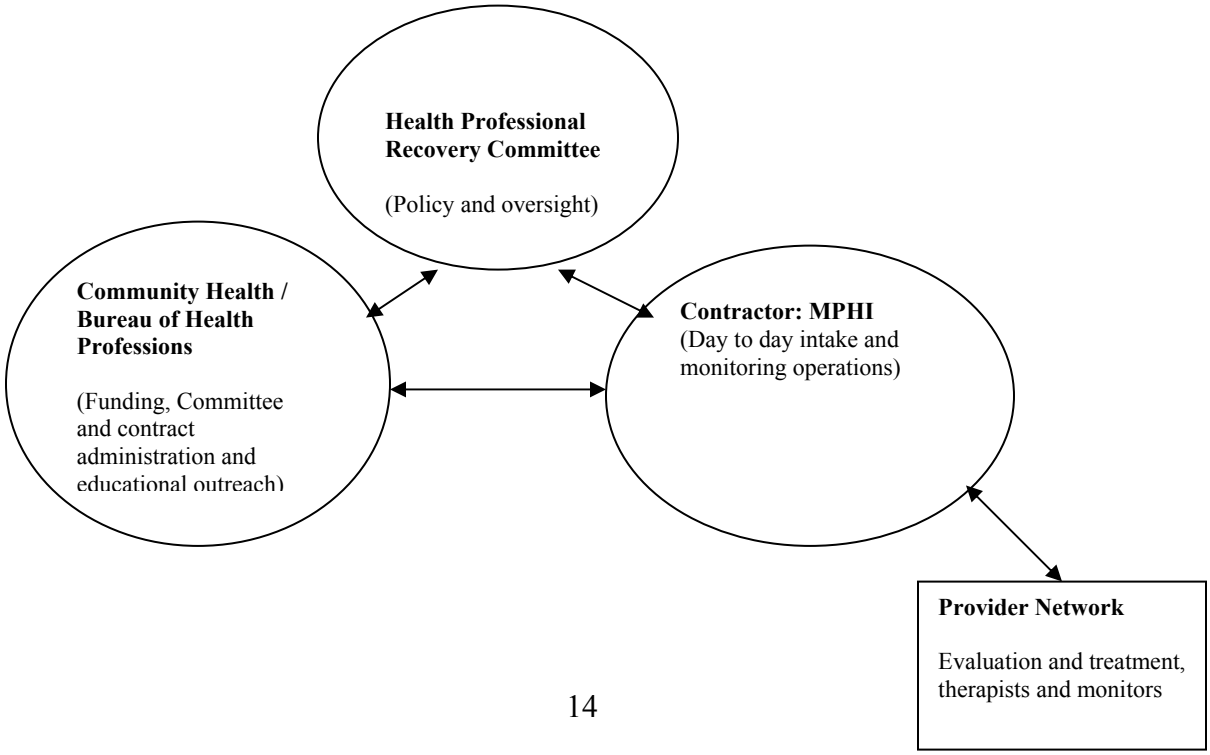
The Michigan Legislature established the Health Professional Recovery Program (HPRP) in 1993 as a voluntary alternative to regulatory discipline for substance use or mental health disorders. Prior to creation of the HPRP, health care professionals with these health problems may have avoided seeking treatment for fear of discovery and regulatory action by their professional licensing board. Program operations began on April 1, 1994. The voluntary HPRP is available to all health care professionals who are professionally credentialed (e.g., licensed, registered, or certified) in Michigan under Article 15 of the Michigan Public Health Code. The program has since evolved to include monitoring of participants who have been mandated by their respective board or disciplinary subcommittee to be involved in the program as a condition to either regain this license or registration to practice, or who as a condition to remain licensed or registered, must be involved with the program. These participants are termed regulatory participants and their involvement in the program is reflected in this report.

Michigan's HPRP relies on the interaction and collaboration of these strategic partnerships:

1. Health Professional Recovery Committee (HPRC):

The Health Professional Recovery Committee, established in the authorizing legislation (P.A. 80 of 1993), oversees the program, develops policies, and provides consultation to the other partners. The Committee is composed of members appointed by the boards of each health profession created under the law plus two public members appointed by the Director of the Department of Community Health (MDCH).

Figure 1. Program Organizational Overview



2. Current Program Contractor:

The authorizing legislation requires that MDCH enter into a contract with a private entity to act as a consultant to assist the committee with the administration of the program. Prior to June 2004, the Michigan Health Professional Recovery Corporation operated the program. Between June and December 2004, the contract was assigned to Compass Vision Inc., out of Oregon. Since December 2004, the Michigan Public Health Institute (MPHI) has been the primary contractor for the state and administers the day-to-day operations of the HPRP in accordance with the authorizing legislation and the policies and procedures established by the HPRC. In addition, they are responsible for the regulatory monitoring of participants on behalf of MDCH Bureau of Health Professions.

3. Department of Community Health (MDCH)/ Bureau of Health Professions

The MDCH Bureau of Health Professions provides contract administration and administrative support to the HPRC. License and renewal fees collected by the Bureau fund the HPRP contract through the Health Professions Regulatory Fund pursuant to section 333.16315 of the Public Health Code.

4. Provider Network:

The contractor previously recruited, verified the quality, and coordinated referrals to a network of approved providers. The providers in the network are required by HPRP policies to have expertise and experience in evaluation, treatment, and aftercare services for health care professionals. These duties will now be addressed by the new Outreach Worker position who is currently in the process of bureau selection.

DESCRIPTION OF PROGRAM PHASES

The health care professionals participating in the HPRP encounter some or all of the following phases:

1. **Intake:** During the intake phase, the HPRP participant:

   - Provides information to the HPRP that is used internally and for statistical data and referral purposes.

   - Receives a referral to at least two approved evaluators, and the participant selects their evaluator. The purpose of the evaluation is to determine if the health care professional has a qualifying condition (substance use and/or mental health disorders).

   - Receives primary treatment appropriate to the diagnosis (unless recently discharged from appropriate treatment).

   - Signs an individualized recovery monitoring agreement (RMA) if a qualifying condition is indicated in the evaluation. This written agreement, between the health care professional and the HPRP, defines the terms and requirements to be followed during the agreement period. Some parts of the agreement (e.g., treatment appointments, random drug screens or attendance at individual/group therapy) are standardized based on a "best practices" model for recovery. Other parts of the agreement (e.g., duration and drug screening frequency) are individualized.

   The intake phase is completed upon signing the recovery monitoring agreement (RMA) that permits the health care professional to move to the monitoring phase of the program. Health care professionals who: (a) refuse to obtain an evaluation or (b) receive a qualifying diagnosis but do not sign an RMA are considered non-compliant. They are discharged and are then reported to MDCH as required by law. Health professionals who are evaluated and found not to have a qualifying condition are considered compliant and discharged.

   Regulatory participants generally follow a similar process. If a licensing board order or consent order agreement describes a different process, the regulatory document is considered primary in terms of the requirements for participation.

2. **Monitoring:** During the monitoring phase, the HPRP participant:

- Receives monitoring for compliance with the RMA (generally lasting between one to three years),

- Receives approval to return to work when the qualifying condition is stabilized and providers notify the HPRP that safe practice expectations are met,

- Complies with RMA stipulations, and

- Addresses non-compliance issues with the HPRP. Consequences for non-compliance may include removal from work and a more intense level of treatment.

The monitoring phase is completed and the participant moves to the discharge phase when: (a) compliance with the RMA has been achieved or (b) non-compliance with the RMA occurs. Deaths or severe incapacitation, incarceration, voluntary surrender of license, lapsed license, without finances, and revoked releases for health care professionals during the monitoring process are reflected as administrative discharges.

3. Discharge: HPRP participants are discharged for the following reasons:

- **Compliant Discharge:** *(Completion of HPRP requirements)*
  This occurs:

  (1) At the intake phase following completion of intake requirements. This means that an evaluation has taken place and no qualifying condition was diagnosed.

  (2) At the monitoring phase when RMA requirements have been satisfactorily completed.

- **Non-compliant Discharge:** *(Failure to complete HPRP requirements)*
  This occurs:

  (1) At the intake phase when it is determined that intake requirements were not completed, such as failure to obtain an evaluation or receiving a qualifying diagnosis and not signing an RMA.

  (2) At the monitoring phase when it is determined that monitoring requirements were not met.

  All cases determined to be non-compliant are discharged and referred to the MDCH Bureau of Health Professions for possible regulatory action. The health care professional who was a voluntary case may re-enter the monitoring program as a regulatory participant if the licensing board requires re-admission as part of a Consent Order (negotiated agreement between MDCH or the Department of Attorney General and the health care professional) or a Board Order.

- **Administrative Discharge:** (*Criteria not met)* Deaths or severe incapacitation, incarceration, voluntary surrender of license, lapsed license, without finances, and revoked releases for health care professionals during the intake process, are reflected as administrative discharges. As with other types of discharges, this may happen during the intake or monitoring phases. The contractor notifies the MDCH Bureau of Health Professions of administrative discharges as required by law.

KEY DEFINITIONS

1. Voluntary Participants

Eligible health care professionals may confidentially report themselves to the HPRP if they are experiencing a substance use and/or a mental health issue. The HPRP supports employee assistance programs (EAP) and treatment providers in their efforts to encourage clients to self-report to HPRP. Referrals may also be received from professional colleagues, employers, family members, friends, and the Department of Community Health (MDCH) Bureau of Health Professions. Under the authorizing legislation, participation in the HPRP on a voluntary basis is not subject to disclosure under the Freedom of Information Act or subpoena. However, the HPRP is not a "hiding place" to avoid legal problems associated with substance use or mental health issues. For example, a health care professional may be participating in the HPRP to address a substance use disorder while also dealing with a criminal charge of drug diversion.

The contractor uses HPRC guidelines and clinical expertise to determine whether a monitored health care professional is in compliance with the signed recovery monitoring agreement.

2. Regulatory Participants

Regulatory participants have been referred to the contractor under the terms of either a Consent Order (a negotiated agreement) or a board order issued by a licensing board's disciplinary subcommittee as a condition of regaining or maintaining their license or registration to practice their profession. Regulatory board action by a disciplinary subcommittee may be due to non-compliance with a voluntary HPRP monitoring contract or other issues.

Although health care professionals who are in regulatory monitoring are following essentially the same process as voluntary participants, involvement in the program is usually a term of probation. These disciplinary actions are considered public information under the Freedom of Information Act, and pursuant to the Public Health Code, the contractor is required to report non-compliance issues to MDCH, as these would be considered a probation violation.

3. Readmissions

A readmission is defined as more than one admission. For example, this could be due to a regulatory admission following a non-compliant discharge. A health care professional who completed program requirements could relapse and be readmitted.

For purposes of accurately reflecting the number of referrals and discharges, the number of cases admitted to the program is counted, rather than the number of health care professionals. Thus, if a health care professional is discharged from the voluntary program and readmitted as a regulatory participant, he or she will be counted as two separate cases.

4. Disclaimer:

The numbers contained as the date of this report accurately reflect the current status of cases in the program, while the actual number of individuals who have participated in the program is impossible to gauge. This is due in large part to the program having had three contractors during this reporting period and the numbers reflect a compilation, and best-guess approximation, of data as determined by MPHI.

FINDINGS

Michigan's Health Professional Recovery Program (HPRP) has recently completed its eleventh year of service to the public and eligible health care professionals. The program, under the auspices of the Department of Community Health (MDCH) Bureau of Health Professions, is designed to protect the public while encouraging and monitoring the health care professional's recovery from the treatable diseases of substance use disorders, and/or mental health disorders.

As part of the review, participation is evaluated by program phase, with special attention paid to the current number of active cases, as well as to examine discharges more closely to determine their compliance or non-compliance with the program's requirements.

A summary of participation, including active participants at the intake and monitoring phases, as well as compliant and non-compliant discharges follows.

Participation by Phase:

For the eighteen month period from April 1, 2004 to September 30, 2005 there have been 1,443 cases at some phase of program participation.

Figure 2 provides a flow chart that shows the multiple pathways within the three program phases (i.e., intake, monitoring, and discharge) that participants have traveled, and tracks the number of participants along these routes.

Table 1 (refer to page 29) summarizes participation information by program phase for each profession. Nurses continue to comprise the majority of program participants at 1001 (69.4%).

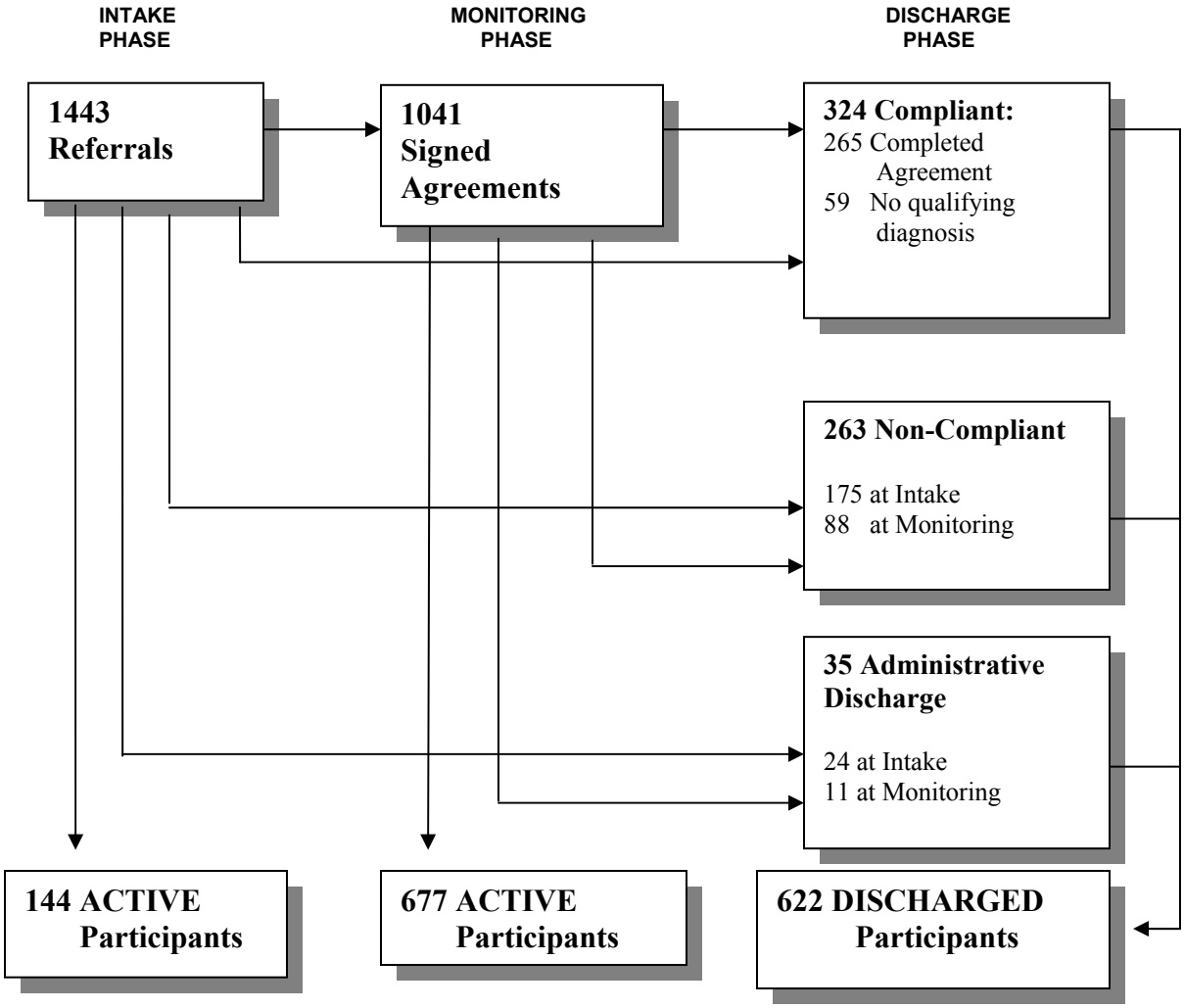
Figure 3 describes the number of active cases at the intake phase and monitoring phase. Of the 821 active participants in the program, 17.5% (n=144) are active at the intake phase and 82.5% (n=677) are active at the monitoring phase.

Figure 4 details numbers of cases that have been discharged arising from the intake and monitoring phases. Forty-three percent (n=622) of the program participants from April 1, 2004 through September 30, 2005 have been discharged for a variety of reasons. Of the 622 cases that were discharged, 9.5% (n=59) were discharged after completing the intake phase for no qualifying diagnosis. Another 28.1% (n=175) were discharged during the intake phase for non-compliance. Of those discharged during or after the monitoring phase, 72.8% (n=265) were discharged after meeting the program requirements and 24.2% (n=88) were discharged during the monitoring phase for non-compliance. A total of 35 individuals received discharges due to administrative reasons (e.g., death or severe incapacitation). Eleven of these occurred during the monitoring phase and 24 occurred during intake. Administrative discharges account for 5.6% of all discharges.

Compliance and Non-Compliance:

Figure 5. illustrates overall compliance with the program's requirements. Of the 1,408 cases in the program, 81.3% (n=1,145) of the participants were found to be compliant. The remaining 18.7% (n=263) found to be non-compliant were discharged and referred to MDCH for further action. Since the 35 administrative discharges are a separate classification from compliant/non-compliant, they are not included in the analysis.

FIGURE 2. **Flowchart Showing Number of Participants by Program Phase**
Report Period: April 1, 2004 – September 30, 2005
Voluntary and Regulatory Cases Combined; (n=1,443)



Intake Phase - Compliant
- 144 are in the active intake phase
- 59 had no qualifying diagnosis

Monitoring Phase - Compliant
- 677 are in the active monitoring phase
- 265 completed their recovery monitoring agreement

Administrative Discharge
- 24 were granted an administrative discharge during the intake phase
- 11 were granted an administrative discharge during the monitoring phase

Discharge Phase – Non-Compliant
- 175 were discharged during intake *(did not obtain an evaluation or obtained a qualifying evaluation and did not sign a monitoring agreement)*
- 88 were discharged during monitoring for non-compliance

FIGURE 3. **Active Participants**
Reporting Period: April 1, 2004 – September 30, 2005
Population: Voluntary and Regulatory Combined
(n = 821)

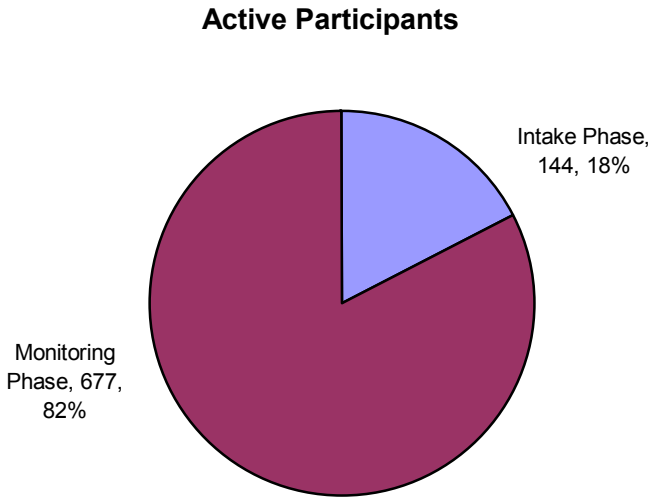


FIGURE 4. **Discharged Participants**
Reporting Period: April 1, 2004 – September 30, 2005
Population: Voluntary and Regulatory Combined
(n = 622)

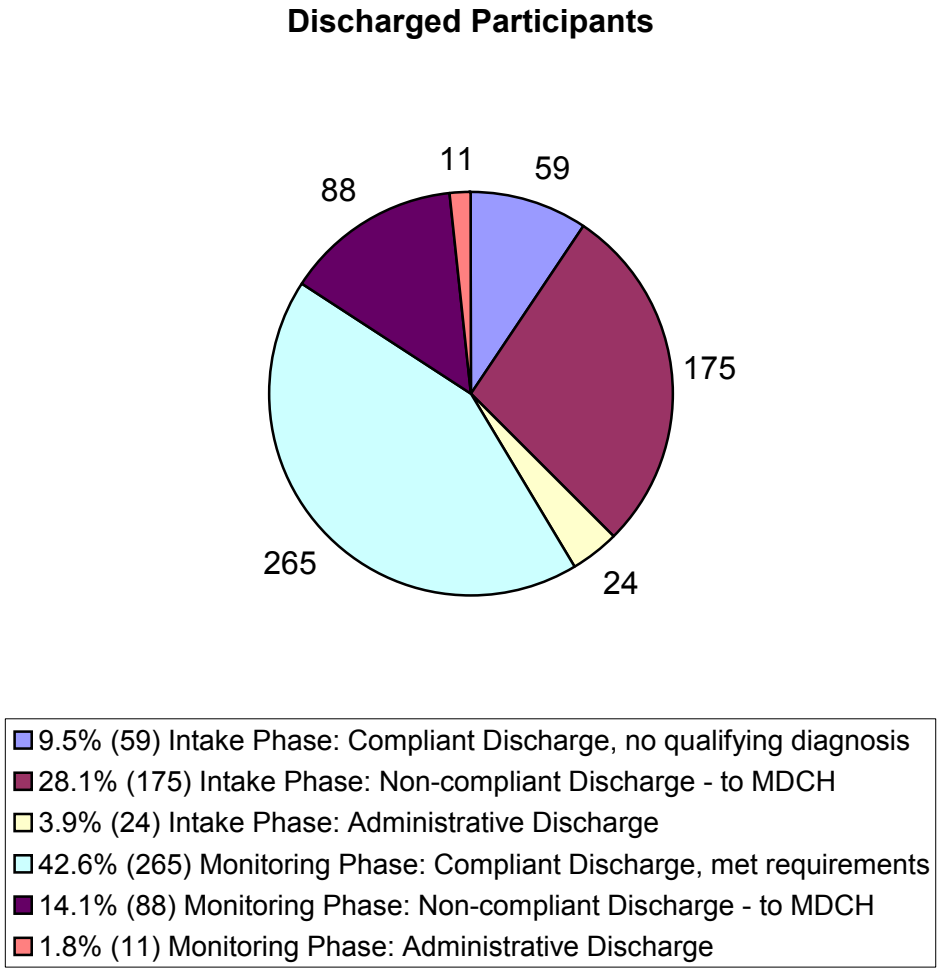
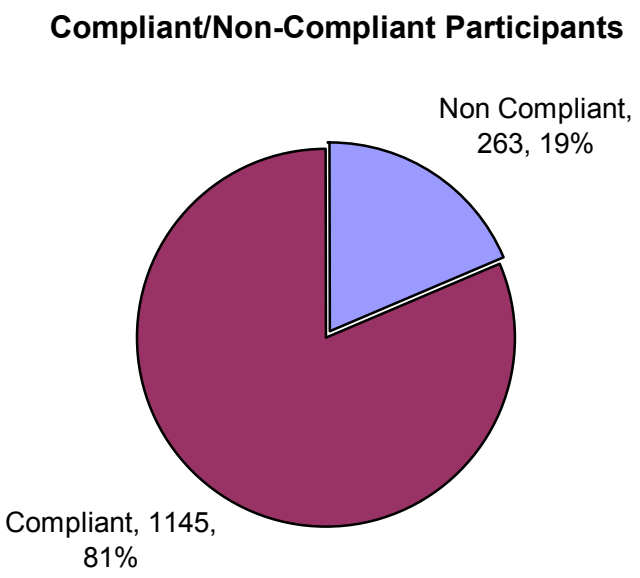


FIGURE 5. Overall Program Compliance
Report Period: April 1, 2004 – Sept. 30, 2005
Population: Voluntary and Regulatory Combined
(n= 1408*)



COMPLIANT:

■	144	10.2%	Active at Intake Phase
■	677	48.1%	Active at Monitoring Phase
■	59	4.2%	Discharged at Intake Phase – No qualifying diagnosis
■	265	18.8%	Discharged at Monitoring Phase – Completed program
	1145	81.3%	Total Compliant

NON-COMPLIANT

■	175	12.4%	Discharge at Intake Phase
■	88	6.3%	Discharge at Monitoring Phase
	263	18.7%	Total Non-Compliant

*Administrative discharges (n=35) are not included in the total because they do not meet the criteria for compliance or non-compliance. Administrative discharges account for less than one percent of all referrals.

Findings by Program Phases: Intake

As of September 30, 2005, 144 individuals were actively participating in the Intake Phase. This represents 10.0% of all participants (n=1443) who participated in the program between April 1, 2004 and September 30, 2005.

Participation by Profession:

As of September 30, 2005, 317,849 health care professionals from 30 categories plus 7 student categories were eligible to participate in HPRP *(see Table 1).* In addition to detailing current numbers of eligible health care professionals in each discipline, Table 2 summarizes total referral numbers for each discipline over the 18 month period from April 1, 2004 to September 30, 2005.

Not all eligible disciplines have experienced referrals to the HPRP. Ninety percent or 27 out of 30 health professions eligible for HPRP services have participated. Audiologists were eligible for HPRP services as of this year, but none contacted or were referred to the program. Further, there were no Registered Dental Assistants participating in the program during this reporting period.

Five health care professions comprise 91.8% of the individuals involved in the program during this reporting period, either active or discharged (*see Table 3).* These disciplines include Nurses (n=1001), Doctor of Medicine (n=146), Pharmacists (n=82), Doctor of Osteopathic Medicine (n=48) and Doctor of Dental Surgery (n=48). Note that these findings cannot be used to make statements linking referral numbers within any specific profession to estimates of incidence or prevalence rates related to substance use disorders, or mental health disorders because there are multiple, alternative explanations for why and how individuals enter the HPRP. For example, findings indicate that the nursing profession exhibits the highest number of referrals to the HPRP. The HPRP lacks information to determine whether: (1) higher numbers of referrals for nurses than other health professions is a direct reflection of the proportionately greater numbers of nurses in Michigan (s*ee Table 2*), (2) nurses are more likely to be referred to the HPRP or MDCH than other eligible health professions, or (3) there may be a higher occurrence of these health problems within the nursing profession.

Participation by Referral Source:

Table 4 shows the referrals to the HPRP by referral source and profession. The authorizing legislation in Section 333.16170a provides for confidential reports to be made to the HPRP by other health care professionals. However, the greatest referral source (41.6%) to the HPRP originated from state government offices (i.e. Department of Attorney General, MDCH Complaint & Allegation Division, or MDCH Licensing Division).

Treatment centers, therapists, and employee assistance programs (EAP) are also listed as referral sources. They accounted for a total of 18.9% of all referrals. Because these sources are bound by confidentiality regulations, it is likely that the referrals originating from these sources include health care professionals who self-report to the HPRP at the recommendation of the treatment center or EAP.

Despite the denial often associated with these conditions, 17.7% of the referrals to the HPRP during the reporting period were self-reports made by the health care professionals in question. The number of reports arising from other health care professionals (including 1.1% from colleagues) indicates there is still considerable work to be done to help promote reporting requirements and the benefits of the program among health care professionals. However, it is also likely health care professionals influence reporting by other referral sources (e.g., self-reports, employers, EAP) by indirectly expressing concerns to these referral sources in lieu of making direct referrals/reports.

Therefore, although this data is interesting and provides an opportunity to view the scope of referral sources to the HPRP, it appears that identifying referral sources is more complex than Table 4 suggests.

Length of Time in Intake Phase:

The Committee has established 45 days or less as the target time to complete the Intake phase. Information about the 144 cases currently active in the Intake phase is summarized below.

Duration of Intake	Percent	Number
■ Less than or equal to 45 days	41.0%	n= 59 of 144
■ More than 45 days at intake:	59.0%	n= 85 of 144

As shown in Table 5, 59.0% (n=85 of 144) of the health care professionals in Intake exceeded 45 days as of September 30, 2005. A participant is maintained in Intake if the intake specialist and team feel progress towards a monitoring agreement is being made. Of those beyond 45 days, 43.5% (n=37 of 85) of those with data indicating the reason for the delay, are currently in treatment, are waiting for extended or additional evaluation results, or are waiting for additional treatment records.

The primary reasons for a case exceeding the 45 day deadline is due to contractor processing and transition issues, active treatment during Intake, and/or the difficulty for the participant to fund their treatment. The HPRC expects the program contractor to reduce the length of time a case is in the Intake phase to at least the previous data report amount of 18%.

Compliance at Intake Phase:

Compliance at the Intake phase is determined by the following processes:

1. Referred health care professionals who are "active" at the Intake phase are considered compliant.
2. Referred health care professionals who obtained an evaluation, did not have a qualifying diagnosis, and subsequently were discharged are considered compliant.
3. Referred health care professionals who obtained an evaluation, have a qualifying diagnosis, and signed a written recovery monitoring agreement are considered compliant.

Compliant	Percent	Number
■ Intake - Active	38.1%	n= 144 of 378
■ Intake - No qualifying diagnosis	15.6%	n= 59 of 378
■ Intake – Non-compliant	46.3%	n= 175 of 378

The compliance rate during the Intake phase is 53.7%.

Demographic Information:

Demographic information is routinely gathered during the Intake phase. The purposes of capturing certain demographics are to provide a profile of the clients in order to help the program become more effective in its focus and outreach and to identify trends over time. However, these demographic findings cannot be used to predict substance use or mental health disorders from this report.

Available demographic characteristics (e.g., profession, mean age, categorical age, gender and marital status) recorded during the Intake phase for program participants during this reporting year are shown below. Table 11 summarizes this demographic information excluding categorical age.

Profession (*see Table 1)*

	Percent	Number
■ Nursing (all types):	69.4%	1001
■ Doctor of Medicine (M.D.):	10.1%	146
■ Pharmacist:	5.7%	82
■ Doctor of Dental Surgery:	3.3%	48
■ Doctor of Osteopathic Medicine (D.O.):	3.3%	48
■ All other types:	8.2%	118
Total	100%	1,443

Mean Age and Standard Deviation (S.D.) – *(see Table 10)*

■ Mean (S.D.)	44.0 years (9.7)

Gender *(see Table 10)*	**Percent**	**Number**
■ Female	63.6%	411
■ Male	36.4%	235
Total	100%	646

Marital Status *(see Table 10)*	**Percent**	**Number**
■ Married:	42.3%	273
■ Divorced	26.6%	172
■ Single:	20.1%	130
■ Separated	3.1%	20
■ Widowed	.9%	6
■ Other (e.g., cohabitation)	.7%	4
■ Missing Data	6.3%	41
Total	100%	646

Findings by Program Phases: Monitoring Phase

As of September 30, 2005, 677 individuals who signed monitoring agreements were actively participating in the Monitoring Phase. This represents 46.9% of all participants (n=1,443) in the eighteen month period from April 1, 2004 to September 30, 2005.

Active Monitoring Agreements:

As of September 30, 2005, the length of time for the current 677 recovery monitoring agreements (RMAs) was as follows:

	Percent	**Number**
■ Out of State RMA *(see Table 6):*	1.6%	11
■ Mental Health RMA *(see Table 7):*	6.8%	46
■ Chemical Dependence RMA *(see Table 8):*	64.3%	435
■ Dual Diagnosis RMA *(see Table 9):*	25.8%	175
■ Pain Management RMA *(see Table 10)*	1.5%	10
Total	100%	677

One-year agreements typically apply to minor substance use disorders, two-year agreements usually are written for mental health disorders, and three-year contracts are generally associated with more serious substance abuse or chemical dependence. The length of the RMA may be modified to exceed the time originally agreed to if there are issues of non-compliance.

Compliance During or After the Monitoring Phase:

Compliance during or after the monitoring phase is determined by the following processes:

1. Only those with a signed or existing monitoring agreement during this reporting period (n=1041) are considered for determination of compliance at the monitoring phase.
2. Referred health care professionals who are "active" at the monitoring phase are considered compliant (n = 677).

3. Referred health care professionals who completed their monitoring agreement and were subsequently discharged are considered compliant (n = 265).

Compliant	Percent	Number
■ Active Participants	65.0%	n= 677 of 1041
■ Compliant Discharges	25.5%	n= 265 of 1041
Total	90.5%	n= 942 of 1041

The compliance rate during the monitoring phase for the reporting year is 90.5%.

Findings by Program Phases: Discharge Phase

During the reporting period September 30, 2005, 622 individuals were discharged from the program for a variety of reasons. This represents 43.1% of all participants (n=1,443) who participated in the program during the reporting year.

The Discharge Phase is not a process phase in comparison to the Intake or Monitoring Phases. Rather, the Discharge Phase describes how the participant ended his/her program participation.

Discharges during the Intake Phase

Forty-one percent (n=258) of all discharges (n=622) occurred during the Intake Phase or directly after individuals completed the Intake Phase.

	Percent	Number
▪ Discharged compliant after intake; no qualifying diagnosis	9.5%	59
▪ Discharged during intake for non-compliance	28.1%	175
▪ Discharged for administrative reasons	3.9%	24
Total	41.5%	258

Discharges during the Monitoring Phase

Fifty-eight percent (n=364) of all discharges (n=622) occurred during the Monitoring Phase or directly after individuals completed the Monitoring Phase.

	Percent	Number
▪ Discharged compliant after monitoring, completed program	42.6%	265
▪ Discharged during monitoring for non-compliance	14.1%	88
▪ Discharged for administrative reasons	1.8%	11
Total	58.5%	364

Compliant/Non-Compliant /Discharge: (see Figure 2 and Table 1)

During this reporting period, the number of discharges according to compliance or non-compliance was 587 since administrative discharges (n=35) are not included. Compliant discharges (n=324) accounted for 55.2% of all discharges and accordingly, non-compliant discharges (n=263) accounted for 44.8% of all discharges.

Compliant Discharges

	Percent	Number
■ Discharge at Intake; no qualifying diagnosis	10.1%	59
■ Discharged at Monitoring; completed monitoring agreement	45.1%	265
Total	55.2%	324

Of the compliant discharges, 45.1% (n=265) were due to the completion of their monitoring agreement. The remaining 10.1% (n=59) were discharged at the Intake phase when an evaluation showed no qualifying condition.

Non-Compliant Discharges

	Percent	Number
■ Discharged at Intake; referred to MDCH	29.8%	175
■ Discharged at Monitoring; referred to MDCH	15.0%	88
Total	44.8%	263

Thirty percent (n=175) of the non-compliant discharges occurred at the Intake phase. This means that either the health care professional had not obtained an evaluation to determine whether entry into the program was appropriate or had obtained a qualifying evaluation and had elected not to enter the program. The reasons for discharge can be complex, such as denial of a problem or a lack of financial or other resources needed for participation. The remaining 15% (n=88) were discharged at some point for non-compliance during monitoring. Non-compliant discharges at monitoring can be due to positive drug screening issues, failure to file reports required in the monitoring agreement, or a lack of financial or other resources to permit continued participation.

Administrative Discharge: (see Figure 2 and Table 1)

Administrative discharges (n=35) represented 5.6% of all discharges (n=622).

	Percent	Number
● Administrative discharge at Intake	68.6%	24
● Administrative discharge at Monitoring phase	31.4%	11
Total	100%	35

APPENDIX A

Tables

Table 1 **Number of Participants by Phase and Profession**
Reporting Period: April 1, 2004 – September 30, 2005
Population: Voluntary and Regulatory Combined (n = 1,443)

	Active		Discharged Noncompliant		Discharged Compliant		Administrative Discharge		Subtotal
Profession	Intake	Monitoring	Intake	Monitoring	Intake	Monitoring	Intake	Monitoring	
Chiropractor	1			1		2			4
Licensed Professional Counselor		3				1			4
Dentistry									
Dentist	5	25	2	4	2	10			48
Registered Dental Hygienist	1	2	1	2		1			7
Registered Dental Assistant									
Marriage & Family Therapist	1	1				1			3
Allopathic Physician	10	76	10	6	9	30	2	3	146
Osteopathic Physician & Surgeon	3	27	4		5	7	1	1	48
Podiatrist	1		1				2		4
Physicians Assistant	4	9	2			7			22
Nursing									
Registered Nurse	72	386	93	52	25	148	12	3	791
Licensed Practical Nurse	28	65	41	12	10	23	5	3	187
Certified Registered Nurse Anesthetist	2	9	2	3	1	6			23
Trained Attendant									
Occupational Therapy									
Occupational Therapist	1					1			2
Occupational Therapy Assistant				1					1
Optometrist		2				2			4
Pharmacist	8	42	8	2	3	18	1		82
Physical Therapist	1	2							3
Psychology									
Psychologist						1			1
Limited License Psychologist		2	1			3			6
Registered Sanitarian		1							1
Social Workers									
Social Worker	2	9	2	1	3				17
Certified Social Worker		9	4			2		1	16
Social Worker Technician		1							1
Veterinary Medicine									
Veterinarian		3	3	2	1	1			10
Veterinary Technician							1		1
Respiratory Therapist	1								1
Audiologist									
Nursing Home Administrator	1								1
Student	2		1	1		1			5
Other		3		1					4
Total	144	677	175	88	59	265	24	11	1443
% of Total	10.0	46.9	12.1	6.1	4.1	18.3	1.7	.8	100%

Table 2 Number of Referrals According to Health Profession

Reporting Period: April 1, 2004 – September 30, 2005

Profession	Licensees as of 9/30/05	Referrals
Chiropractor		1
Licensed Professional Counselor		
Dentistry		
Dentist		20
Registered Dental Hygienist		3
Registered Dental Assistant		
Marriage & Family Therapist		1
Allopathic Physician		61
Osteopathic Physician & Surgeon		25
Podiatrist		2
Physicians Assistant		8
Nursing		
Registered Nurse		348
Licensed Practical Nurse		106
Certified Registered Nurse Anesthetist		5
Trained Attendant		
Occupational Therapy		
Occupational Therapist		1
Occupational Therapy Assistant		
Optometrist		1
Pharmacist		31
Physical Therapist		1
Psychology		
Psychologist		1
Limited License Psychologist		
Registered Sanitarian		1
Social Workers		
Social Worker		8
Certified Social Worker		8
Social Worker Technician		1
Veterinary Medicine		
Veterinarian		5
Veterinary Technician		1
Respiratory Therapist		1
Audiologist		
Nursing Home Administrator		1
Student		2
Other		3
Total		646

Table 3 **Health Professions Associated with the Highest Number of Health Professional Recovery Program Participants***
Reporting Period: April 1, 2004 – September 30, 2005

Profession	Number of Participants
Nursing (RN, LPN, CRNA)	1001
Allopathic Physician (MD)	146
Pharmacists (R.Ph.)	82
Dentists (DDS)	48
Osteopathic Physician & Surgeon (DO)	48
Total	1325

*Only Professions with more than 40 participants are included. These participants represent 91.8% of all individuals in the program.

Table 4 **Number of Participants by Referral Source According to Health Profession**
Reporting Period: April 1, 2004 – September 30, 2005

	Referral Source																Total
	Anonymous	Attorney	Attorney General	Colleague	DCH-CAD	DCH-Licensure	EAP	Employer	Family/Friend	Health Care Org	Patient	Physician	Private Therapist	Treatment Center	Self	None of the above	
Chiropractor		1	1		1									1			4
Limited License Psychologist	1				2			1						1	1		6
Licensed Professional Counselor	1		1											2			4
Dentist		2	5	1	10							1	1	13	14	1	48
Registered Dental Hygienist					5	1							1				7
Marriage & Family Therapist			1												2		3
Allopathic Physician	3	1	13	5	28	12	1	23	2		1	4		20	30	3	146
Osteopathic Physician & Surgeon	2	1	4	1	6	3	1	12				2		5	10	1	48
Podiatrist					2							1				1	4
Physicians Assistant			2	1	7	1	1	1				2		1	6		22
Registered Nurse	14	5	50	6	232	16	80	123	3	2		7	5	93	141	14	791
Licensed Practical Nurse	1	1	17		90	11		30	2			2		10	22	1	187
Certified Registered Nurse Anesthetist		1	1		3		4	4					1	4	5		23
Occupational Therapist														1	1		2
Occupational Therapy Assistant			1														1
Optometrist			1		1										2		4
Pharmacist	1	3	6		24	2	6	6		1		1		13	18	1	82
Physical Therapist		1	1		1												3
Psychologist					1												1
Registered Sanitarian									1								1
Social Worker			1		6	5			1					3	1		17
Certified Social Worker			2	1	6	1		1					1	2	2		16
Social Worker Technician						1											1
Veterinarian			2	1	5									2			10
Veterinary Technician						1											1
Respiratory Therapist															1		1
Nursing Home Administrator					1												1
Student					1	1						1		1		1	5
Other					3	1											4
Total	23	16	109	16	435	56	93	201	9	3	1	21	9	172	256	23	1443
Percentage	1.6	1.1	7.6	1.1	30.1	3.9	6.4	13.9	.6	.2	.1	1.4	.6	11.9	17.7	1.6	100

Table 5 Duration of Intake for Active Participants in the Program as of September 30, 2005 (n = 144)

	≤ 45 Days	>45 Days	Total
In Compliance	59		
In Treatment		9	
Changing Level of Care		1	
Licensee Marginally Compliant		3	
Licensee Unreachable, Trying to locate		8	
No copy of Assessment Received		18	
RMA in Development		12	
Waiting for 2nd Assessment Results		9	
Waiting for Additional Treatment Records		11	
Waiting for Extended Evaluation Results		8	
Waiting for Return of RMA		4	
Waiting for Step Two Review Decision		2	
Total	59 (41.0%)	85 (59.0%)	144

Table 6 **Number of Participants in an Out of State Agreement According to Health Profession – Both Voluntary and Regulatory**
Reporting Date: September 30, 2005 (n = 11)

	One Year Agreement		Two Year Agreement		Three Year Agreement		Over Three Year Agreement		Total
Profession	V*	R*	V*	R*	V*	R*	V*	R*	
Chiropractor									
Licensed Professional Counselor									
Dentistry									
Dentist									
Registered Dental Hygienist							1		1
Registered Dental Assistant									
Marriage & Family Therapist									
Allopathic Physician					2			1	3
Osteopathic Physician & Surgeon						1			1
Podiatrist									
Physicians Assistant									
Nursing									
Registered Nurse					3	2			5
Licensed Practical Nurse						1			1
Certified Registered Nurse Anesthetist									
Trained Attendant									
Occupational Therapy									
Occupational Therapist									
Occupational Therapy Assistant									
Optometrist									
Pharmacist									
Physical Therapist									
Psychology									
Psychologist									
Limited License Psychologist									
Registered Sanitarian									
Social Workers									
Social Worker									
Certified Social Worker									
Social Worker Technician									
Veterinary Medicine									
Veterinarian									
Veterinary Technician									
Respiratory Therapist									
Audiologist									
Nursing Home Administrator									
Student									
Other									
Total					5	4	1	1	11

*V = Voluntary
*R = Regulatory

Table 7 **Number of Participants in a Mental Health Agreement According to Health Profession – Both Voluntary and Regulatory**
Reporting Date: September 30, 2005 (n = 46)

	One Year Agreement		Two Year Agreement		Three Year Agreement		Over Three Year Agreement		Total
Profession	V*	R*	V*	R*	V*	R*	V*	R*	
Chiropractor									
Licensed Professional Counselor			1						1
Dentistry									
Dentist									
Registered Dental Hygienist									
Registered Dental Assistant									
Marriage & Family Therapist									
Allopathic Physician		1	8	1					10
Osteopathic Physician & Surgeon	2		3						5
Podiatrist									
Physicians Assistant		1							1
Nursing									
Registered Nurse	5	2	13	2	1	1			24
Licensed Practical Nurse		1	1						2
Certified Registered Nurse Anesthetist									
Trained Attendant									
Occupational Therapy									
Occupational Therapist									
Occupational Therapy Assistant									
Optometrist									
Pharmacist			2	1					3
Physical Therapist									
Psychology									
Psychologist									
Limited License Psychologist									
Registered Sanitarian									
Social Workers									
Social Worker									
Certified Social Worker									
Social Worker Technician									
Veterinary Medicine									
Veterinarian									
Veterinary Technician									
Respiratory Therapist									
Audiologist									
Nursing Home Administrator									
Student									
Other									
Total	7	5	28	4	1	1			46

*V = Voluntary
*R = Regulatory

Table 8 **Number of Participants in Chemical Dependence Agreements According to Health Profession – Both Voluntary and Regulatory**
Reporting Date: September 30, 2005 (n = 435)

	One Year Agreement		Two Year Agreement		Three Year Agreement		Over Three Year Agreement		Total
Profession	V*	R*	V*	R*	V*	R*	V*	R*	
Chiropractor									
Licensed Professional Counselor						1			1
Dentistry									
Dentist	7				6	2	1		16
Registered Dental Hygienist									
Registered Dental Assistant									
Marriage & Family Therapist									
Allopathic Physician	1	2	3		31	6	1	2	46
Osteopathic Physician & Surgeon	1		1		13	2	1		18
Podiatrist									
Physicians Assistant					5	1			6
Nursing									
Registered Nurse	16	3	11	3	164	29	16	5	247
Licensed Practical Nurse	4	1	1	1	21	14	3		45
Certified Registered Nurse Anesthetist					7				7
Trained Attendant									
Occupational Therapy									
Occupational Therapist									
Occupational Therapy Assistant									
Optometrist					2				2
Pharmacist	3		1		18	5	1		28
Physical Therapist						1			1
Psychology									
Psychologist									
Limited License Psychologist					1				1
Registered Sanitarian					1				1
Social Workers									
Social Worker					4		1		5
Certified Social Worker				1	4	2			7
Social Worker Technician									
Veterinary Medicine									
Veterinarian					1				1
Veterinary Technician									
Respiratory Therapist									
Audiologist									
Nursing Home Administrator									
Student									
Other				1	1	1			3
Total	32	6	17	6	279	64	24	7	435

*V = Voluntary
*R = Regulatory

Table 9 **Number of Participants in a Dual Diagnosis Agreement According to Health Profession – Both Voluntary and Regulatory**
Reporting Date: September 30, 2005 (n = 175)

	One Year Agreement		Two Year Agreement		Three Year Agreement		Over Three Year Agreement		Total
Profession	V*	R*	V*	R*	V*	R*	V*	R*	
Chiropractor									
Licensed Professional Counselor									
Dentistry									
Dentist			1		6	1	1		9
Registered Dental Hygienist					1				1
Registered Dental Assistant									
Marriage & Family Therapist						1			1
Allopathic Physician			3		10	3	1		17
Osteopathic Physician & Surgeon					1	2			3
Podiatrist									
Physicians Assistant					1	1			2
Nursing									
Registered Nurse	1	1	8	7	72	14	1		104
Licensed Practical Nurse			2	1	10	3			16
Certified Registered Nurse Anesthetist					1				1
Trained Attendant									
Occupational Therapy									
Occupational Therapist									
Occupational Therapy Assistant									
Optometrist									
Pharmacist			1		6	4			11
Physical Therapist				1					1
Psychology									
Psychologist									
Limited License Psychologist						1			1
Registered Sanitarian									
Social Workers									
Social Worker	1			1	2				4
Certified Social Worker					1	1			2
Social Worker Technician					1				1
Veterinary Medicine									
Veterinarian						1			1
Veterinary Technician									
Respiratory Therapist									
Audiologist									
Nursing Home Administrator									
Student									
Other									
Total	2	1	15	10	112	32	3		175

*V = Voluntary
*R = Regulatory

Table 10 **Number of Participants in a Pain Management Agreement According to Health Profession – Both Voluntary and Regulatory**
Reporting Date: September 30, 2005 (n = 10)

	One Year Agreement		Two Year Agreement		Three Year Agreement		Over Three Year Agreement		Total
Profession	V*	R*	V*	R*	V*	R*	V*	R*	
Chiropractor									
Licensed Professional Counselor					1				1
Dentistry									
Dentist									
Registered Dental Hygienist									
Registered Dental Assistant									
Marriage & Family Therapist									
Allopathic Physician									
Osteopathic Physician & Surgeon									
Podiatrist									
Physicians Assistant									
Nursing									
Registered Nurse		1	1		3			1	6
Licensed Practical Nurse					1	1			2
Certified Registered Nurse Anesthetist									
Trained Attendant									
Occupational Therapy									
Occupational Therapist									
Occupational Therapy Assistant									
Optometrist									
Pharmacist									
Physical Therapist									
Psychology									
Psychologist									
Limited License Psychologist									
Registered Sanitarian									
Social Workers									
Social Worker									
Certified Social Worker									
Social Worker Technician									
Veterinary Medicine									
Veterinarian		1							1
Veterinary Technician									
Respiratory Therapist									
Audiologist									
Nursing Home Administrator									
Student									
Other									
Total		2	1		5	1		1	10

*V = Voluntary
*R = Regulatory

Table 11 Select Demographic Characteristics for Cases Referred to the Program during the Reporting Period

Reporting Period: April 1, 2004 – September 30, 2005

Population: Voluntary and Regulatory Combined (n = 646)

	Age		Gender		Marital Status							
Profession	Mean	SD*	F	M	Single	Married	Separated	Divorced	Widowed	Domestic Partnership	Other	Total
Chiropractor	34.0			1		1						1
Licensed Professional Counselor												
Dentistry												
Dentist	46.0	6.6	4	16	2	7	2	9				20
Registered Dental Hygienist	49.3	7.5	3			1		1				2
Registered Dental Assistant												
Marriage & Family Therapist	44.0			1		1						1
Allopathic Physician	52.4	11.4	7	54	9	34	3	11				57
Osteopathic Physician & Surgeon	44.6	10.2	3	22	6	15		2		1		24
Podiatrist	56.5	2.1		2		1		1				2
Physicians Assistant	41.1	8.6	5	3	4	2					1	7
Nursing												
Registered Nurse	42.7	9.0	276	72	72	146	13	95	2	2		330
Licensed Practical Nurse	43.1	8.6	90	16	21	29	2	38	4			94
Certified Registered Nurse Anesthetist	46.6	8.0		5		3		1				4
Trained Attendant												
Occupational Therapy												
Occupational Therapist	45.0		1					1				1
Occupational Therapy Assistant												
Optometrist	34.0		1			1						1
Pharmacist	40.1	10.2	6	25	8	17		3				28
Physical Therapist	42.0		1			1						1
Psychology												
Psychologist	43.0			1		1						1
Limited License Psychologist												
Registered Sanitarian	37.0			1		1						1
Social Workers												
Social Worker	43.4	9.1	4	4	4	3		1				8
Certified Social Worker	50.5	8.2	4	4		3		5				8
Social Worker Technician	58.0		1					1				1
Veterinary Medicine												
Veterinarian	51.4	9.4	1	4	1	3		1				5
Veterinary Technician	30.0		1					1				1
Respiratory Therapist	43.0			1	1							1
Audiologist												
Nursing Home Administrator	46.0		1			1						1
Student	33.5	1.5	1	1	1	1						2
Other	36.3	5.7	1	2	1	1		1				3
Total	44.0	9.7	411	235	130	273	20	172	6	3	1	605

*SD = Standard Deviation

APPENDIX B

Glossary of Abbreviations

BHS	Bureau of Health Services
CD	Chemical Dependency
CRNA	Certified Registered Nurse Anesthetist
CSW	Certified Social Worker
DC	Doctor of Chiropractic
DCIS	Department of Consumer & Industry Services
DDS	Doctor of Dental Surgery
DO	Doctor of Osteopathy
DPM	Doctor of Podiatric Medicine
DVM	Doctor of Veterinary Medicine
DX	Diagnosis
HPRC	Health Professional Recovery Committee
HPRP	Health Professional Recovery Program
IRMA	Initial Recovery Monitoring Agreement
LLP	Limited License Psychologist
LP	Licensed Psychologist
LPC	Licensed Professional Counselor
LPN	Licensed Practical Nurse
MD	Medical Doctor
MFT	Marriage and Family Therapist
MI	Mental Illness
MH	Mental Health
MHPRC	Michigan Health Professional Recovery Corporation
n	Number
NA	Not Applicable
NC	Non-Compliant
OD	Doctor of Optometry
OT	Occupational Therapist
OTA	Occupational Therapy Assistant
PA	Physicians Assistant
PhD	Doctor of Philosophy/Psychologist
PM	Pain Management
PT	Physical Therapist

R	Regulatory Cases
RDA	Registered Dental Assistant
RDH	Registered Dental Hygienist
RMA	Recovery Monitoring Agreement
RN	Registered Nurse
RPh	Registered Pharmacist
RS	Registered Sanitarian
S.D.	Standard Deviation
SUD	Substance Use Disorder
SW	Social Worker - Registered
SWT	Social Work Technician
TX	Treatment
UDS	Urine Drug Screen
V	Voluntary

APPENDIX C

Contact Information

State Administrator:

Department of Community Health
Bureau of Health Professions
P.O. Box 30670
Lansing, MI 48909-8170
Attn: HPRP Contract Administrator

Telephone: (517) 335-3294
Fax: (517) 241-3082

Webpage: www.michigan.gov/healthlicense

Health Professional Recovery Committee:

(Please address all committee correspondence and telephone calls to the HPRP Contract Administrator at the above address.)

A list of Committee members is shown on the next page by profession.

Contractor:

Michigan Public Health Institute
3520 Okemos Road #6-182
Okemos, MI 48864
Telephone: (800) 453-3784
Fax: (517) 324-6071

Webpage: www.hprp.org

APPENDIX D

HEALTH PROFESSIONAL RECOVERY COMMITTEE MEMBERSHIP

Appointed by	Committee Member
Board of Osteopathy	Thomas P. Kane, D.O. (HPRC Chairperson and Chairperson, Appeal Subcommittee)
Board of Chiropractic	James C. Spencer, Sr., D.C.
Board of Counseling	Shirley A. Brogan, M.A., L.P.C. (Chairperson, Education & Outreach Subcommittee)
Board of Dentistry	Joel Grand, D.D.S. (HPRC Vice-Chairperson & Chairperson, Clinical & Policy Subcommittee)
Board of Marriage & Family Therapy	Lori Hall, MSW, CSW, LMF
Board of Medicine	Herbert L. Malinoff, MD, FACP
Board of Nursing Home Administrators	Cindy Bosley, NHA
Board of Occupational Therapy	JoAnn Crain, Ph.D., OTR
Board of Social Work	William S. Paxton, ACSW (Chairperson, Data & Statistics Subcommittee)
Board of Physical Therapy	R. Elizabeth Black, P.T.
Board of Nursing	Barbara Socie, R.N., MLS
Board of Optometry	Roger L. Kuhlman, O.D.
Board of Pharmacy	Charles H. Newman, R.Ph.
Physicians Assistant Task Force	John G. McGinnity, M.S., P.A.-C
Board of Podiatry	Mary E. Barna, D.P.M.
Board of Psychology	Thomas J. Gordon, Ph.D.
Board of Veterinary Medicine	Paula Rode, D.V.M.
MDCH Director: Sanitarian	Steven C. Hall, R.S.
MDCH Director: Public Member:	Two Positions - Vacant
MDCH Director: Ex-Officio Member	Melanie Brim, Director, Bureau of Health Professions